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The Ethics of Addiction

Lest we take for granted that we know what drug addiction is, let us begin with some definitions.

According to the World Health Organization's Expert Committee on Drugs Liable to Produce Addiction,

> Drug addiction is a state of periodic or chronic intoxication detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include: (1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means, (2) a tendency to increase the dosage, and (3) a psychic (psychological) and sometimes physical dependence on the effects of the drug.[1]

Since this definition hinges on the harm done to the individual and to society by the consumption of the drug, it is clearly an ethical one. Moreover, by not specifying what is "detrimental" or who shall ascertain it and on what grounds, this definition immediately assimilates the problem of addiction with other psychiatric problems in which psychiatrists define the patient's dangerousness to himself and others. Actually, physicians regard as detrimental what people do to themselves but not what they do to people. For example, when college students smoke marijuana, that is detrimental; but when psychiatrists administer psychotropic drugs to involuntary mental patients, that is not detrimental.

1. Quoted in L. C. Kolb, *Noyes' Modern Clinical Psychiatry*, 7th ed. (Philadelphia: Saunders, 1968), p. 516.

The rest of the definition proposed by the World Health Organization is of even more dubious value. It speaks of an "overpowering desire" or "compulsion" to take the drug and of efforts to obtain it "by any means." Here again, we sink into the conceptual and semantic morass of psychiatric jargon. What is an "overpowering desire" if not simply a desire by which we choose to let ourselves be overpowered? And what is a "compulsion" if not simply an unresisted inclination to do something, and keep on doing it, even though someone thinks we should not be doing it?

Next, we come to the effort to obtain the addictive substance "by any means." That suggests that the substance is prohibited, or is very expensive for some other reason, and is hence difficult to obtain for the ordinary person rather than that the person who wants it has an inordinate craving for it. If there were an abundant and inexpensive supply of what the "addict" wants, there would be no reason for him to go to "any means" to obtain it. Does the World Health Organization's definition mean that one can be addicted only to a substance that is illegal or otherwise difficult to obtain? If so—and there is obviously some truth to the view that forbidden fruit tastes sweeter, although it cannot be denied that some things are sweet regardless of how the law treats them—then that surely removes the problem of addiction from the sphere of medicine and psychiatry and puts it squarely into that of morals and law.

The definition of addiction offered in *Webster's Third New International Dictionary of the English Language, Unabridged* exhibits the same difficulties. It defines addiction as "the compulsory uncontrolled use of habit-forming drugs beyond the period of medical need or under conditions harmful to society." This definition imputes lack of self-control to the addict over his taking or not taking a drug, a dubious proposition at best; at the same time, by qualifying an act as an addiction depending on whether or not it harms society, it offers a moral definition of an ostensibly medical condition.

Likewise, the currently popular term *drug abuse* places this behavior squarely in the category of ethics. For it is ethics that deals with the right and wrong uses of man's powers and possessions.

Clearly, drug addiction and drug abuse cannot be defined without specifying the proper and improper uses of certain pharmacologically active agents. The regular administration of morphine by a physician

to a patient dying of cancer is the paradigm of the proper use of a narcotic, whereas even its occasional self-administration by a physically healthy person for the purpose of pharmacological pleasure is the paradigm of drug abuse.

I submit that these judgments have nothing whatever to do with medicine, pharmacology, or psychiatry. They are moral judgments. Indeed, our present views on addiction are astonishingly similar to some of our former views on sex. Intercourse in marriage with the aim of procreation used to be the paradigm of the proper use of one's sexual organs, whereas intercourse outside of marriage with the aim of carnal pleasure used to be the paradigm of their improper use. Until recently, masturbation—or self-abuse, as it was called—was professionally declared and popularly accepted as both the cause and the symptom of a variety of illnesses.[2]

To be sure, it is now virtually impossible to cite a contemporary American (or foreign) medical authority to support the concept of self-abuse. Medical opinion now holds that there is simply no such thing, that whether a person masturbates or not is medically irrelevant, and that engaging in the practice or refraining from it is a matter of personal morals or life-style. On the other hand, it is now virtually impossible to cite a contemporary American (or foreign) medical authority to oppose the concept of drug abuse. Medical opinion now holds that drug abuse is a major medical, psychiatric, and public-health problem; that drug addiction is a disease similar to diabetes, requiring prolonged (or lifelong) and carefully supervised medical treatment; and that taking or not taking drugs is primarily, if not solely, a matter of medical concern and responsibility.

Like any social policy, our drug laws may be examined from two entirely different points of view—technical and moral. Our present inclination is either to ignore the moral perspective or to mistake the technical for the moral.

An example of our misplaced overreliance on a technical ap-

2. See my *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement* (New York: Harper & Row, 1970), pp. 180–206.

proach to the so-called drug problem is the professionalized mendacity about the dangerousness of certain types of drugs. Since most of the propagandists against drug abuse seek to justify certain repressive policies by appeals to the alleged dangerousness of various drugs, they often falsify the facts about the true pharmacological properties of the drugs they seek to prohibit. They do so for two reasons: first, because many substances in daily use are just as harmful as the substances they want to prohibit; second, because they realize that dangerousness alone is never a sufficiently persuasive argument to justify the prohibition of any drug, substance, or artifact. Accordingly, the more the "addiction-mongers" ignore the moral dimensions of the problem, the more they must escalate their fraudulent claims about the dangers of drugs.

To be sure, some drugs are more dangerous than others. It is easier to kill oneself with heroin than with aspirin. But it is also easier to kill oneself by jumping off a high building than a low one. In the case of drugs, we regard their potentiality for self-injury as justification for their prohibition; in the case of buildings, we do not.

Furthermore, we systematically blur and confuse the two quite different ways in which narcotics may cause death—by a deliberate act of suicide and by accidental overdosage.

As I have suggested elsewhere, we ought to consider suicide a basic human right.[3] If so, it is absurd to deprive an adult of a drug (or of anything else) because he might use it to kill himself. To do so is to treat everyone the way institutional psychiatrists treat the so-called suicidal mental patient: they not only imprison such a person but take everything away from him—shoelaces, belts, razor blades, eating utensils, and so forth—until the "patient" lies naked on a mattress in a padded cell, lest he kill himself. The result is the most degrading tyrannization in the annals of human history.

Death by accidental overdose is an altogether different matter. But can anyone doubt that this danger now looms so large precisely because the sale of narcotics and many other drugs is illegal? People who buy illicit drugs cannot be sure what drug they are getting or how much of it. Free trade in drugs, with governmental action limited to safeguarding the purity of the product and the veracity

3. See Chapter 6, "The Ethics of Suicide."

of the labeling, would reduce the risk of accidental overdose with "dangerous drugs" to the same levels that prevail, and that we find acceptable, with respect to other chemical agents and physical artifacts that abound in our complex technological society.

Although this essay is not intended as an exposition on the pharmacological properties of narcotics and other mind-affecting drugs, it might be well to say something more about the medical and social dangers they pose. Before proceeding to that task, I want to make clear, however, that in my view, regardless of their dangerousness, all drugs should be legalized (a misleading term I employ reluctantly as a concession to common usage). Although I recognize that some drugs—notably heroin, the amphetamines, and LSD among those now in vogue—may have undesirable personal or social consequences, I favor free trade in drugs for the same reason the Founding Fathers favored free trade in ideas: in an open society, it is none of the government's business what idea a man puts into his mind; likewise, it should be none of the government's business what drug he puts into his body.

It is a fundamental characteristic of human beings that they get used to things: one becomes habituated, or addicted, not only to narcotics, but to cigarettes, cocktails before dinner, orange juice for breakfast, comic strips, sex, and so forth. It is similarly a fundamental characteristic of living organisms that they acquire increasing tolerance to various chemical agents and physical stimuli: the first cigarette may cause nothing but nausea and headache; a year later, smoking three packs a day may be pure joy. Both alcohol and opiates are addictive, then, in the sense that the more regularly they are used, the more the user craves them and the greater his tolerance for them becomes. However, there is no mysterious process of "getting hooked" involved in any of this. It is simply an aspect of the universal biological propensity for learning, which is especially well-developed in man. The opiate habit, like the cigarette habit or the food habit, can be broken—usually without any medical assistance —provided the person wants to break it. Often he doesn't. And why indeed should he if he has nothing better to do with his life? Or as happens to be the case with morphine, if he can live an essentially normal life while under its influence? That, of course, sounds com-

pletely unbelievable, or worse—testimony to our "addiction" to half a century of systematic official mendacity about opiates, which we can break only by suffering the intellectual withdrawal symptoms that go with giving up treasured falsehoods.

Actually, opium is much less toxic than alcohol. Moreover, just as it is possible to be an alcoholic and work and be productive, so it is (or rather, it used to be) possible to be an opium addict and work and be productive. Thomas De Quincey and Samuel Taylor Coleridge were both opium takers, and "Kubla Khan," considered one of the most beautiful poems in the English language, was written while Coleridge was under the influence of opium.[4] According to a definitive study by Light and others published by the American Medical Association in 1929, "morphine addiction is not characterized by physical deterioration or impairment of physical fitness. . . . There is no evidence of change in the circulatory, hepatic, renal, or endocrine functions. When it is considered that these subjects had been addicted for at least five years, some of them as long as twenty years, these negative observations are highly significant."[5] In a 1928 study, Lawrence Kolb, an assistant surgeon general of the United States Public Health Service, found that of 119 persons addicted to opiates through medical practice, 90 had good industrial records and only 29 had poor ones:

> Judged by the output of labor and their own statements, none of the normal persons had their efficiency reduced by opium. Twenty-two of them worked regularly while taking opium for twenty-five years or more; one of them, a woman aged 81 and still alert mentally, had taken 3 grains of morphine daily for 65 years. [The usual therapeutic dose is ¼ grain, 3 to 4 grains being fatal for the nonaddict.] She gave birth to and raised six children, and managed her household affairs with more than average efficiency. A widow, aged 66, had taken 17 grains of morphine daily for most of 37 years. She is alert mentally . . . does physical labor every day, and makes her own living.[6]

4. A. Montagu, "The Long Search for Euphoria," *Reflections* 1 (May–June 1966): 65.

5. A. B. Light et al., *Opium Addiction* (Chicago: American Medical Association, 1929), p. 115; quoted in Alfred R. Lindesmith, *Addiction and Opiates* (Chicago: Aldine, 1968). p. 40.

6. L. Kolb, "Drug Addiction: A Study of Some Medical Cases," *Archives of Neurology and Psychiatry* 20 (1928): 178; quoted in Lindesmith, *Addiction and Opiates*, pp. 41–42.

I am not citing this evidence to recommend the opium habit. The point is that we must, in plain honesty, distinguish between pharmacological effects and personal inclinations. Some people take drugs to cope—to help them function and conform to social expectations. Others take them to cop out—to ritualize their refusal to function and conform to social expectations. Much of the drug abuse we now witness—perhaps nearly all of it—is of the second type. But instead of acknowledging that addicts are unable or unfit or unwilling to work and be normal, we prefer to believe that they act as they do because certain drugs—especially heroin, LSD, and the amphetamines—make them sick. If only we could get them well, so runs this comfortable and comforting view, they would become productive and useful citizens. To believe that is like believing that if an illiterate cigarette smoker would only stop smoking, he would become an Einstein. With a falsehood like that, one can go far. No wonder that politicians and psychiatrists love it.

The idea of free trade in drugs runs counter to another cherished notion of ours—namely, that everyone must work and that idleness is acceptable only under special conditions. In general, the obligation to work is greatest for healthy adult white males. We tolerate idleness on the part of children, women, blacks, the aged, and the sick, and we even accept the responsibility of supporting them. But the new wave of drug abuse affects mainly young adults, often white males who are, in principle at least, capable of working and supporting themselves. But they refuse: they drop out, adopting a life-style in which *not* working, *not* supporting oneself, *not* being useful to others, are positive values. These people challenge some of the most basic values of our society. It is hardly surprising, then, that society wants to retaliate, to strike back. Even though it would be cheaper to support addicts on welfare than to "treat" them, doing so would be legitimizing their life-style. That, "normal" society refuses to do. Instead, the majority acts as if it felt that, so long as it is going to spend its money on addicts, it is going to get something out of it. What society gets out of its war on addiction is what every persecutory movement provides for the persecutors: by defining a minority as evil (or sick), the majority confirms itself as good (or healthy). (If that can be done for the victim's own good, so much the better.) In short, the war on addiction is a part of that vast

modern enterprise which I have named the "manufacture of madness." It is indeed a therapeutic enterprise, but with this grotesque twist: its beneficiaries are the therapists, and its victims are the patients.

Most of all perhaps, the idea of free trade in narcotics frightens people because they believe that vast masses of our population would spend their days and nights smoking opium or mainlining heroin instead of working and shouldering their responsibilities as citizens. But that is a bugaboo that does not deserve to be taken seriously. Habits of work and idleness are deep-seated cultural patterns; I doubt that free trade in drugs would convert industrious people from hustlers into hippies at the stroke of a legislative pen.

The other side of the economic coin regarding drugs and drug controls is actually far more important. The government is now spending millions of dollars—the hard-earned wages of hard-working Americans—to support a vast and astronomically expensive bureaucracy whose efforts not only drain our economic resources and damage our civil liberties but create ever more addicts and, indirectly, the crime associated with the traffic in illicit drugs. Although my argument about drug taking is moral and political and does not depend upon showing that free trade in drugs would also have fiscal advantages over our present policies, let me indicate briefly some of the economic aspects of the drug-control problem.

On April 1, 1967, New York State's narcotics addiction-control program, hailed as "the most massive ever tried in the nation," went into effect. "The program, which may cost up to $400 million in three years," reported *The New York Times,* "was hailed by Governor Rockefeller as 'the start of an unending war.' "[7] Three years later, it was conservatively estimated that the number of addicts in the state had tripled or quadrupled. New York State Senator John Hughes reported that the cost of caring for each addict during that time was $12,000 per year (as against $4,000 per year for patients in state mental hospitals).[8] It was a great time, though, for some of the ex-addicts themselves. In New York City's Addiction Services Agency, one ex-addict started at $6,500 a year

7. *The New York Times,* April 1, 1967.
8. Editorial, "About Narcotics," *Syracuse Herald-Journal,* March 6, 1969.

on November 27, 1967, and was making $16,000 seven months later. Another started at $6,500 on September 12, 1967, and went up to $18,100 by July 1, 1969.[9] The salaries of the medical bureaucrats in charge of the programs are similarly attractive. In short, the detection and rehabilitation of addicts is good business; and so was, in former days, the detection and rehabilitation of witches. We now know that the spread of witchcraft in the late Middle Ages was due more to the work of witchmongers than to the lure of witchcraft. Is it not possible that, similarly, the spread of addiction in our day is due more to the work of addictmongers than to the lure of narcotics?

Let us see how far some of the money spent on the war on addiction could go in supporting people who prefer to drop out of society and drug themselves. Their habit itself would, of course, cost next to nothing, for free trade would bring the price of narcotics down to a negligible amount. During the 1969–1970 fiscal year, the New York State Narcotics Addiction Control Commission had a budget of nearly $50 million, not including the budget for capital construction. Using that figure as a tentative base for calculation, here is what we come to: $100 million will support thirty thousand people at $3,300 per year; since the population of New York State is roughly one-tenth that of the nation, we arrive at a figure of $500 million to support one hundred and fifty thousand addicts nationally.

I am not advocating that we spend our hard-earned money in this way. I am only trying to show that free trade in narcotics would be more economical for those of us who work, even if we had to support legions of addicts, than is our present program of trying to "cure" them. Moveover, I have not even made use, in my economic estimates, of the incalculable sums we would thus save by reducing crimes now engendered by the illegal traffic in drugs.

Clearly, the argument that marijuana—or heroin, or methadone, or morphine—is prohibited because it is addictive or dangerous cannot be supported by facts. For one thing, there are many drugs —from insulin to penicillin—that are neither addictive nor danger-

9. *The New York Times*, June 29, 1970.

ous but are nevertheless also prohibited—they can be obtained only through a physician's prescription. For another, there are many things—from dynamite to guns—that are much more dangerous than narcotics (especially to others) but are not prohibited. As everyone knows, it is still possible in the United States to walk into a store and walk out with a shotgun. We enjoy that right not because we do not believe that guns are dangerous, but because we believe even more strongly that civil liberties are precious. At the same time, it is not possible in the United States to walk into a store and walk out with a bottle of barbiturates, codeine, or other drugs. We are now deprived of that right because we have come to value medical paternalism more highly than the right to obtain and use drugs without recourse to medical intermediaries.

I submit, therefore, that our so-called drug-abuse problem is an integral part of our present social ethic, which accepts "protections" and repressions justified by appeals to health similar to those that medieval societies accepted when they were justified by appeals to faith.[10] Drug abuse (as we now know it) is one of the inevitable consequences of the medical monopoly over drugs—a monopoly whose value is daily acclaimed by science and law, state and church, the professions and the laity. As the Church formerly regulated man's relations to God, so Medicine now regulates his relations to his body. Deviation from the rules set forth by the Church was then considered to be heresy and was punished by appropriate theological sanctions, called *penance*; deviation from the rules set forth by Medicine is now considered to be drug abuse (or some sort of mental illness) and is punished by appropriate medical sanctions, called *treatment*.

The problem of drug abuse will thus be with us so long as we live under medical tutelage. This is not to say that if all access to drugs were free, some people would not medicate themselves in ways that might upset us or harm them. That of course is precisely what happened when religious practices became free.

What I am suggesting is that although addiction is ostensibly a medical and pharmacological problem, actually it is a moral and

10. See my *Ideology and Insanity: Essays on the Psychiatric Dehumanization of Man* (Garden City, N.Y.: Doubleday, Anchor Press, 1970).

political problem. We talk as if we were trying to ascertain which drugs *are* toxic, but we act as if we were trying to decide which drugs *ought to be* prohibited.

We ought to know, however, that there is no necessary connection between facts and values, between what is and what ought to be. Thus, objectively quite harmful acts, objects, or persons may be accepted and tolerated—by minimizing their dangerousness. Conversely, objectively quite harmless acts, objects, or persons may be prohibited and persecuted—by exaggerating their dangerousness. It is always necessary to distinguish—and especially so when dealing with social policy—between description and prescription, fact and rhetoric, truth and falsehood.

To command adherence, social policy must be respected; and to be respected, it must be considered legitimate. In our society, there are two principal methods of legitimizing policy—social tradition and scientific judgment. More than anything else, time is the supreme ethical arbiter. Whatever a social practice might be, if people engage in it generation after generation, then that practice becomes acceptable.

Many opponents of illegal drugs admit that nicotine may be more harmful to health than marijuana; nevertheless, they argue that smoking cigarettes should be legal but smoking marijuana should not be, because the former habit is socially accepted while the latter is not. That is a perfectly reasonable argument. But let us understand it for what it is—a plea for legitimizing old and accepted practices and illegitimizing novel and unaccepted ones. It is a justification that rests on precedence, not on evidence.

The other method of legitimizing policy, increasingly more important in the modern world, is through the authority of science. In matters of health, a vast and increasingly elastic category, physicians thus play important roles as legitimizers and illegitimizers. One result is that, regardless of the pharmacological effects of a drug on the person who takes it, if he obtains it through a physician and uses it under medical supervision, that use is, ipso facto, legitimate and proper; but if he obtains it through nonmedical channels and uses it without medical supervision (and especially if the drug is illegal and the individual uses it solely for the purpose of altering his mental state), then that use is, ipso facto, illegitimate and im-

proper. In short, being medicated by a doctor is drug use, while self-medication (especially with certain classes of drugs) is drug abuse.

That too is a perfectly reasonable arrangement. But let us understand it for what it is—a plea for legitimizing what doctors do, because they do it with good, therapeutic intent; and for illegitimizing what laymen do, because they do it with bad, self-abusive (masturbatory) intent. It is a justification that rests on the principles of professionalism, not of pharmacology. That is why we applaud the systematic medical use of methadone and call it "treatment for heroin addiction," but decry the occasional nonmedical use of marijuana and call it "dangerous drug abuse."

Our present concept of drug abuse thus articulates and symbolizes a fundamental policy of scientific medicine—namely, that a layman should not medicate his own body but should place its medical care under the supervision of a duly accredited physician. Before the Reformation, the practice of true Christianity rested on a similar policy—namely, that a layman should not himself commune with God but should place his spiritual care under the supervision of a duly accredited priest. The self-interests of the Church and of Medicine in such policies are obvious enough. What might be less obvious is the interest of the laity in them: by delegating responsibility for the spiritual and medical welfare of the people to a class of authoritatively accredited specialists, those policies—and the practices they ensure—relieve individuals from assuming the burdens of those responsibilities for themselves. As I see it, our present problems with drug use and drug abuse are just one of the consequences of our pervasive ambivalence about personal autonomy and responsibility.

Luther's chief heresy was to remove the priest as intermediary between man and God, giving the former direct access to the latter. He also demystified the language in which man could henceforth address God, approving for that purpose what until then had significantly been called the *vulgar tongue*. Perhaps it is true that familiarity breeds contempt: Protestantism was not just a new form of Christianity, but the beginning of its end, at least as it had been known until then.

I propose a medical reformation analogous to the Protestant Reformation—specifically, a "protest" against the systematic mystification of man's relationship to his body and his professionalized separation from it. The immediate aim of the reform would be to remove the physician as intermediary between man and his body and to give the layman direct access to the language and contents of the pharmacopoeia. It is significant that until recently physicians wrote prescriptions in Latin and that medical diagnoses and treatments are still couched in a jargon whose chief aim is to awe and mystify the laity. If man had unencumbered access to his own body and the means of chemically altering it, it would spell the end of Medicine, at least as we now know it. That is why, with faith in Medicine so strong, there is little interest in this kind of medical reform: physicians fear the loss of their privileges; laymen, the loss of their protections.

Our present policies with respect to drug use and drug abuse thus constitute a covert plea for legitimizing certain privileges on the part of physicians and illegitimizing certain practices on the part of everyone else. The upshot is that we act as if we believed that only doctors should be allowed to dispense narcotics, just as we used to believe that only priests should be allowed to dispense holy water.

Finally, since luckily we still do not live in the utopian perfection of one world, our technical approach to the drug problem has led, and will undoubtedly continue to lead, to some curious attempts to combat it.

In one such attempt, the American government succeeded in pressuring Turkey to restrict its farmers from growing poppy (the source of opium, morphine, and heroin).[11] If turnabout is fair play, perhaps we should expect the Turkish government to pressure the United States to restrict its farmers from growing barley. Or should we assume that Muslims have enough self-control to leave alcohol alone but Christians need all the controls politicians, policemen, and physicians, both native and foreign, can bring to bear on them to enable them to leave opiates alone?

11. "Pursuit of the Poppy," *Time*, September 14, 1970, p. 28.

In another such attempt, the California Civil Liberties Union sued to enforce a paroled heroin addict's "right to methadone maintenance treatment."[12] In this view, the addict has more rights than the nonaddict: for the former, methadone, supplied at the taxpayer's expense, is a right; for the latter, methadone, supplied at his own expense, is evidence of addiction to it.

I believe that just as we regard freedom of speech and religion as fundamental rights, so we should also regard freedom of self-medication as a fundamental right; and that instead of mendaciously opposing or mindlessly promoting illicit drugs, we should, paraphrasing Voltaire, make this maxim our rule: I disapprove of what you take, but I will defend to the death your right to take it!

To be sure, like most rights, the right of self-medication should apply only to adults; and it should not be an unqualified right. Since these are important qualifications, it is necessary to specify their precise range.

John Stuart Mill said (approximately) that a person's right to swing his arm ends where his neighbor's nose begins. Similarly, the limiting condition with respect to self-medication should be the inflicting of actual (as against symbolic) harm on others.

Our present practices with respect to alcohol embody and reflect this individualistic ethic. We have the right to buy, possess, and consume alcoholic beverages. Regardless of how offensive drunkenness might be to a person, he cannot interfere with another person's right to become inebriated so long as that person drinks in the privacy of his own home or at some other appropriate location and so long as he conducts himself in an otherwise law-abiding manner. In short, we have a right to be intoxicated—in private. Public intoxication is considered to be an offense against others and is therefore a violation of the criminal law.

The same principle applies to sexual conduct. Sexual intercourse, especially between husband and wife, is surely a right. But it is a right that must be exercised at home or at some other appropriate location; it is not a right in a public park or on a downtown street.

12. "CLU Says Addict Has Right to Use Methadone," *Civil Liberties*, July 1970, p. 5.

It makes sense that what is a right in one place may become, by virtue of its disruptive or disturbing effect on others, an offense somewhere else.

The right to self-medication should be hedged in by similar limits. Public intoxication, not only with alcohol but with any drug, should be an offense punishable by the criminal law. Furthermore, acts that may injure others—such as driving a car—should, when carried out in a drug-intoxicated state, be punished especially strictly and severely. The habitual use of certain drugs, such as alcohol and opiates, may also harm others indirectly by rendering the subject unmotivated for working and thus unemployed. In a society that supports the unemployed, such a person would, as a consequence of his own conduct, place a burden on the shoulders of his working neighbors. How society might best guard itself against that sort of hazard I cannot discuss here. However, it is obvious that prohibiting the use of habit-forming drugs offers no protection against that risk, but only adds to the tax burdens laid upon the productive members of society.

The right to self-medication must thus entail unqualified responsibility for the effects of one's drug-intoxicated behavior on others. For unless we are willing to hold ourselves responsible for our own behavior and hold others responsible for theirs, the liberty to ingest or inject drugs degenerates into a license to injure others. But here is the catch: we are exceedingly reluctant to hold people responsible for their misbehavior. That is why we prefer diminishing rights to increasing responsibilities. The former requires only the passing of laws, which can then be more or less freely violated or circumvented; whereas the latter requires prosecuting and punishing offenders, which can be accomplished only by just laws justly enforced. The upshot is that we increasingly substitute tenderhearted tyranny for tough-spirited liberty.

Such then would be the situation of adults were we to regard the freedom to take drugs as a fundamental right similar to the freedom to read and to worship. What would be the situation of children? Since many people who are now said to be drug addicts or drug abusers are minors, it is especially important that we think clearly about this aspect of the problem.

I do not believe, and I do not advocate, that children should have a right to ingest, inject, or otherwise use any drug or substance they want. Children do not have the right to drive, drink, vote, marry, or make binding contracts. They acquire those rights at various ages, coming into their full possession at maturity, usually between the ages of eighteen and twenty-one. The right to self-medication should similarly be withheld until maturity.

In this connection, it is well to remember that children lack even such basic freedoms as the opportunity to read what they wish or worship God as they choose, freedoms we consider elementary rights for adult Americans. In those as well as other important respects, children are wholly under the jurisdiction of their parents or guardians. The disastrous fact that many parents fail to exercise proper authority over the conduct of their children does not, in my opinion, justify depriving adults of the right to engage in conduct we deem undesirable for children. That remedy only further aggravates the situation. For if we consider it proper to prohibit the use of narcotics by adults to prevent their abuse by children, then we would have to consider it proper also to prohibit sexual intercourse, driving automobiles, piloting airplanes—indeed virtually everything!—because those activities too are likely to be abused by children.

In short, I suggest that "dangerous" drugs be treated more or less as alcohol and tobacco are treated now. (That does not mean that I believe the state should make their use a source of tax revenue.) Neither the use of narcotics nor their possession should be prohibited, but only their sale to minors. Of course, that would result in the ready availability of all kinds of drugs among minors—though perhaps their availability would be no greater than it is now but only more visible and hence more easily subject to proper controls. That arrangement would place responsibility for the use of all drugs by children where it belongs: on parents and their children. That is where the major responsibility rests for the use of alcohol and tobacco. It is a tragic symptom of our refusal to take personal liberty and responsibility seriously that there appears to be no public desire to assume a similar stance toward other dangerous drugs.

Consider what would happen should a child bring a bottle of gin to school and get drunk there. Would the school authorities blame

the local liquor stores as pushers? Or would they blame the parents and the child himself? There is liquor in practically every home in America and yet children rarely bring liquor to school, whereas marijuana, LSD, and heroin—substances that children do not find in the home and whose very possession is a criminal offense—frequently find their way into the school.

Our attitude toward sexual activity provides another model for our attitude toward drugs. Although we generally discourage children below a certain age from engaging in sexual activities with others (we no longer "guard" them against masturbation), we do not prohibit such activities by law. What we do prohibit by law is the sexual seduction of children by adults. The pharmacological seduction of children by adults should be similarly punishable. In other words, adults who give or sell drugs to children should be regarded as offenders. Such a specific and limited prohibition—contrasted with the kind of generalized prohibitions that we had under the Volstead Act or have now against countless drugs—would be relatively easy to enforce. Moreover, it would probably be rarely violated, for there would be little psychological interest and no economic profit in doing so. On the other hand, the use of drugs by and among children (without the direct participation of adults) should be a matter entirely outside the scope of the criminal law, just as is their engaging in sexual activities under like circumstances.

There is of course a fatal flaw in my proposal. Its adoption would remove minors from the ranks of our most cherished victims: we could no longer spy on them and persecute them in the name of protecting them from committing drug abuse on themselves—a practice we have substituted for our spying on them and persecuting them in order to protect them from committing self-abuse on themselves (that is, masturbating).[13] Hence, we cannot, and indeed we shall not, abandon such therapeutic tyrannization and treat children as young persons entitled to dignity from us and owing responsibility to us until we are ready to cease psychiatrically oppressing children—"in their own best interests."

13. See *The Manufacture of Madness*, chap. 11.

Sooner or later, we shall have to confront the basic moral dilemma underlying our drug problem: does a person have the right to take a drug—any drug—not because he needs it to cure an illness, but because he wants to take it?

The Declaration of Independence speaks of our inalienable right to "life, liberty, and the pursuit of happiness." How are we to interpret that phrase? By asserting that we ought to be free to pursue happiness by playing golf or watching television but not by drinking alcohol, or smoking marijuana, or ingesting amphetamines?

The Constitution and the Bill of Rights are silent on the subject of drugs. Their silence would seem to imply that the adult citizen has, or ought to have, the right to medicate his own body as he sees fit. Were that not the case, why should there have been a need for a constitutional amendment to outlaw drinking? But if ingesting alcohol was, and is now again, a constitutional right, is ingesting opium, or heroin, or barbiturates, or anything else not also such a right? If it is, then the Harrison Narcotic Act is not only a bad law but unconstitutional as well, because it prescribes in a legislative act what ought to be promulgated in a constitutional amendment.

The nagging questions remain. As American citizens, do we and should we have the right to take narcotics or other drugs? Further, if we take drugs and conduct ourselves as responsible and law-abiding citizens, do we and should we have a right to remain unmolested by the government? Lastly, if we take drugs and break the law, do we and should we have a right to be treated as persons accused of a crime rather than as patients accused of being mentally ill?

These are fundamental questions that are conspicuous by their absence from all contemporary discussions of problems of drug addiction and drug abuse. In this area as in so many others, we have allowed a moral problem to be disguised as a medical question and have then engaged in shadowboxing with metaphorical diseases and medical attempts, ranging from the absurd to the appalling, to combat them.

The result is that instead of debating the use of drugs in moral and political terms, we define our task as the ostensibly narrow technical problem of protecting people from poisoning themselves

with substances for whose use they cannot possibly assume responsibility. That, I think, best explains the frightening national consensus against personal responsibility for taking drugs and for one's conduct while under their influence. In 1965, for example, when President Johnson sought a bill imposing tight federal controls over "pep pills" and "goof balls," the bill cleared the House by a unanimous vote, 402 to 0.

The failure of such measures to curb the "drug menace" has served only to inflame our legislators' enthusiasm for them. In October 1970, the Senate passed, again by a unanimous vote (54 to 0), "a major narcotics crackdown bill hailed as a keystone in President Nixon's anticrime program. Added to the bill were strong new measures for the treatment and rehabilitation of drug abusers."[14] In December 1971, the Senate approved—this time by a unanimous vote of 92 to 0—a "$1 billion-plus bill to mount the nation's first all-out, coordinated attack on the insidious menace of drug abuse";[15] in February 1972, the House voted 380 to 0 for a $411 million, three-year program to combat drug abuse; and in March, the House voted 366 to 0, to authorize a $1 billion three-year federal attack on drug abuse.

To me, such unremitting unanimity on this issue can mean one thing only: an evasion of the actual problem and an attempt to master it by attacking and overpowering a scapegoat—"dangerous drugs" and "drug abusers." There is an ominous resemblance between the unanimity with which all "reasonable" men—especially politicians, physicians, and priests—formerly supported the protective measures of society against witches and Jews and now support them against drug addicts and drug abusers.

Finally, those repeated unanimous votes on far-reaching measures to combat drug abuse are bitter reminders that when the chips are really down, that is, when democratic lawmakers can preserve their intellectual and moral integrity only by going against certain popular myths, they prove to be either mindless or spineless. They prefer running with the herd to courting unpopularity and risking reelection.

14. *Syracuse Post-Standard*, October 8, 1970.
15. *The International Herald Tribune*, December 4–5, 1971.

After all is said and done—after millions of words are written, thousands of laws are enacted, and countless numbers of people are "treated" for "drug abuse"—it all comes down to whether we accept or reject the ethical principle John Stuart Mill so clearly enunciated in 1859:

> The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forebear because it will make him happier, because, in the opinions of others, to do so would be wise, or even right. . . . In the part [of his conduct] which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.[16]

The basic issue underlying the problem of addiction—and many other problems, such as sexual activity between consenting adults, pornography, contraception, gambling, and suicide—is simple but vexing: in a conflict between the individual and the state, where should the former's autonomy end and the latter's right to intervene begin?

One way out of the dilemma lies through concealment: by disguising the moral and political question as a medical and therapeutic problem, we can, to protect the physical and mental health of patients, exalt the state, oppress the individual, and claim benefits for both.

The other way out of it lies through confrontation: by recognizing the problem for what it is, we can choose to maximize the sphere of action of the state at the expense of the individual or of the individual at the expense of the state. In other words, we can commit ourselves to the view that the state, the representative of many, is more important than the individual and that it therefore has the right, indeed the duty, to regulate the life of the individual in the best interests of the group. Or we can commit ourselves to the view that individual dignity and liberty are the supreme values of life and that the foremost duty of the state is to protect and promote those values.

In short, we must choose between the ethic of collectivism and the ethic of individualism and pay the price of either—or of both.

16. J. S. Mill, *On Liberty* (Chicago: Regnery, 1955), p. 13.